## DIVISION OF LICENSING PROGRAMS VIRGINIA DEPARTMENT OF SOCIAL SERVICES

## RENEWAL APPLICATION FOR A STATE LICENSE TO OPERATE AN ASSISTED LIVING FACILITY

This application shall be signed by the individual responsible for the operation of the assisted living facility (ALF) or, if the facility is to be operated by a board, by an officer of the board, preferably the chairman. The completed application shall be filed prior to the expiration of the current license and, to assure timely processing, should be filed at least 60 days before the current license expires. Answer each question on the application, i.e., do not refer to previous applications on this form.

Application is hereby made for a license to operate an assisted living facility pursuant to Chapters 17 and 18, Title 63.2 of the Code of Virginia.

Name of Assisted Living Facility: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Facili	ity Location:			
	Street or Route Number	City	State	Zip Code
Maili	ng Address:			
	Street, Route or Box Number	r City	State	Zip Code
In ma	king this application, I state that:			
1.	I am in receipt of and have read a copy of the lice facilities.	ensing statute and the standards and	l regulations applications	able to assisted living
2.	I certify that it is my intent to comply with the afore them if I am so licensed.	mentioned standards, regulations and	statutes and to rema	ain in compliance with
3.	I grant permission to the Department of Social S circumstances surrounding this application and any review of records, and interviews of my agents, emp that, following licensure, authorized agents of the determine its compliance with standards and regulations.	statement made herein, including for oyees, and any adult or other person. Department will make announced a	inancial status, insp within my custody cand unannounced v	pection of the facility or control. I understand
4.	I understand that I will be required to supply reports	from the local health department and	appropriate fire prev	vention officials.
5.	I understand that an application for a license is sunderstood that I have appeal rights that are explained			event of denial, it is
6.	I am aware that it is a misdemeanor for any person t duties, make false or untrue reports with respect to t without first obtaining a license, or serve more person	ne operation of the facility, engage in	the operation of an	
7.	To the best of my knowledge and belief, all informauthorized agents is true and correct. I will supply to			
		Date		
	Name of Applicant (Individ	ual or Organization Applying for I	Licensure)	
By: _				
	Signature	Applicant's Mailing Addre	ss if different from	the ALF
	Name (Please Print)	City, State, 2	Zip Code	
	Title (Please Print)	Business Tel	ephone	

032-05-025/4 (Revised: 9/02)

	I. GENERAL INFORMATION			•
A.	Name of individual, partnership, corporation, limited liability company, unincorporapplying for the license:			_
В.	Administration of the assisted living facility:  1. Name of the administrator:  2. Name of the designated assistant administrator, if any:			_
C.	Number of persons now residing in the facility:  1. Residents: Male Female Total Residents  2. Family Members  3. Employees  4. Others (specify roles)  5. TOTAL			
	II. LICENSURE AND PROGRAM INFORMA (Attach additional pages if more space is needed.)	TION		
Α.	Maximum number of residents license requested for:			_
В.	Number of buildings license requested for:			-
C.	Request for licensure level: (check applicable level)  I request licensure for residential living care only.  I request licensure for both residential living care and assisted living care	÷.		
D.	Specify the current number of residents assessed for:  Residential living care  Regular assisted living care  Intensive assisted living care  NOTE: The number of residents in these three categories should add up to the facil population.	ity's total c	urrent resident	
<b>Е</b> .	Does the facility provide care for residents who:  are nonambulatory?  have mental illness or mental retardation or who are substance abusers?  have a history of aggressive behavior?  need the use of restraints?  have a serious cognitive impairment and cannot recognize danger or protect their own safety and welfare?	Yes Yes	No No No No	

Yes \_\_\_\_ No \_\_\_

3.

F.	Describe the special needs of the residents, such as skilled nursing treatments, special diets, assistance with medication rehabilitative services:									
G.	Have there been any changes in the purpose of the assisted living facility, the characteristics of the population served, the program, the services provided or the physical plant since the facility's last license was issued (i.e., during the current licensure period)?  Yes No									
	If "yes," describe these changes:									
Н.	Describe any changes planned for the future:									
	III. ADDITIONAL MATERIAL TO BE INCLUDED AS PART OF THE APPLICATION									
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A.	The appropriate fee for application processing.									
B.	A statement or chart regarding sponsorship of the assisted living facility and organization of the management staff, with information showing who is responsible for policy, operation and management decisions.									
C.	A copy of any rules, requirements or policies of the assisted living facility that have changed since the facility's last license was issued.									
	Attached Not Applicable									
D.	If the applicant is a partnership, corporation, limited liability company, unincorporated association or public agency, the names and addresses of (1) any agent who has direct involvement with management of the assisted living facility and (2) the following persons as applicable: (Specify the office or position held by each person.)									
	1. For a partnership, all the General Partners.									
	2. For a <u>corporation</u> , the officers of the corporation, including the president, senior vice-presidents, secretary, treasurer and any other officer who has direct involvement with management of the assisted living facility.									

4. For an <u>unincorporated association</u>, the officers of the board/association.

For a <u>limited liability company</u>, all the members and each manager.

5. For a <u>public agency</u>, the person responsible for the overall operation of the agency and any agency staff person who has direct involvement with management of the assisted living facility.

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NAME OF FACILITY:	DATE:

If there are 25 or fewer employees, each employee must be listed separately. If there are more than 25 employees, the number of employees in each position, working in the same building, on the same shift, may be indicated in the column "NAME." List the specific hours to be worked in the "Work Schedule." NOTE: First Aid and CPR should be marked only when a person has a *current* certificate issued as specified in the ALF standards.

be marked only when a person has a curr						WORK SCHEDULE								
NAME	POSITION	POSITION 1ST AID C	MED ADMIN	BLDG	Mon	Tues	Wed	Thurs	Fri	Sat	Sun			

## Renewal Application – ALF Staff Information Sheet (Continued) Page 5 of 5 Staff Information Sheet (Continued)

		1 <sup>ST</sup>		MED		WORK SCHEDULE								
NAME	POSITION	AID	CPR	ADMIN	BLDG	Mon	Tues	Wed	Thurs	Fri	Sat	Sun		